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CONTENTS

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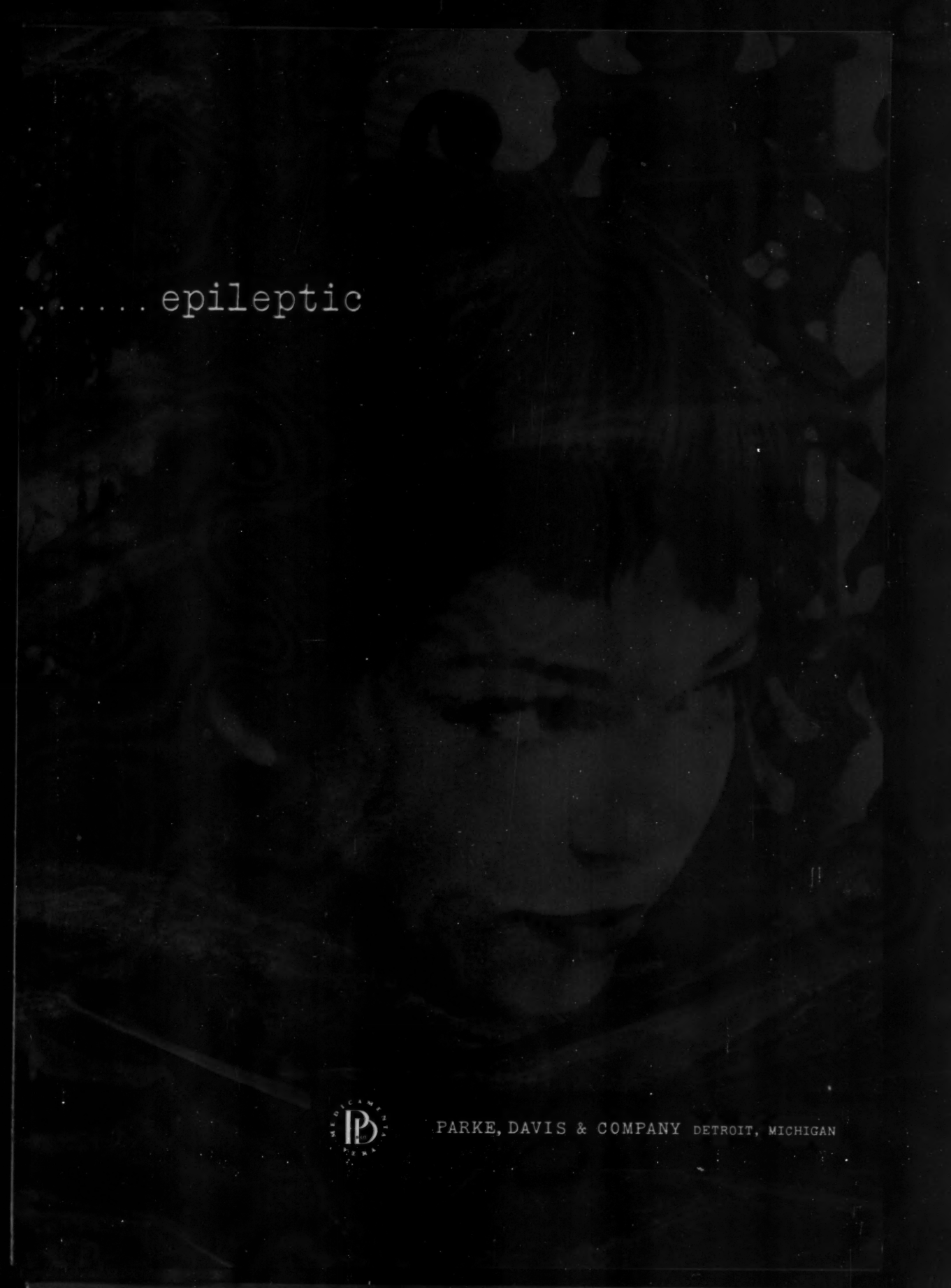

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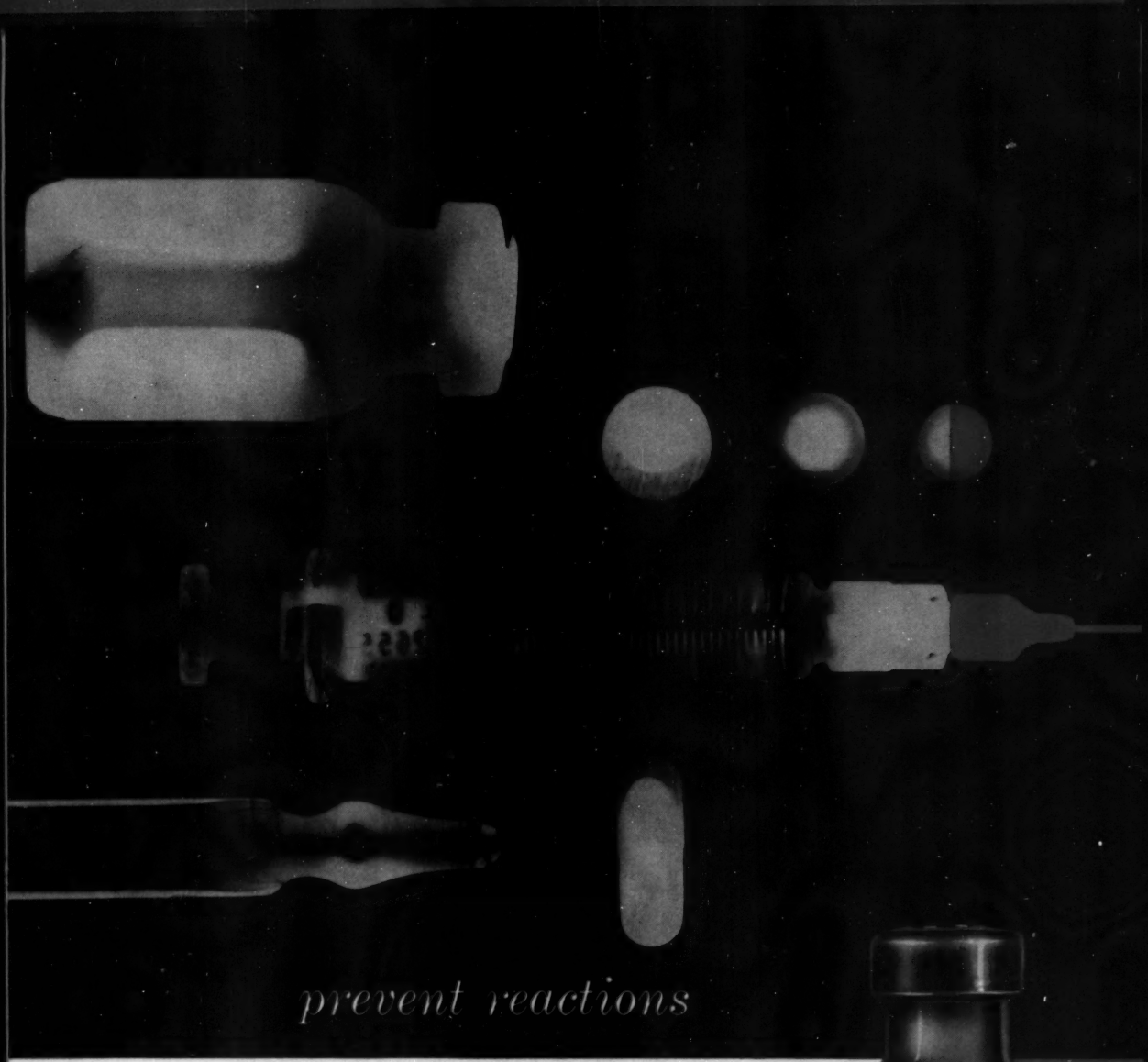

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Pork rates among the foremost sources of thiamine. As a source of all other B vitamins and many essential minerals, such as iron and phosphorus, pork meat is considered an important dietary constituent.

Lean pork is virtually completely digestible. Its protein serves to promote growth and aid in the maintenance of tissue cells. Like all high quality protein, that of pork aids in the elaboration of protein hormones, enzymes, and antibodies.

Pork constitutes a valuable part of the daily diet (Table I), and also contributes importantly to the nutrition of the pregnant woman (Table II).

Pork and pork products have won America's favor by their unique combination of economy, palatability, and nutritional value.

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1. Consumption of Food in the United States, 1909-1952, Washington, D.C., United States Department of Agriculture, Bureau of Agricultural Economics, Agricultural Handbook No. 62, September, 1953.
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8. Recommended Dietary Allowances, Washington, D.C., National Academy of Sciences—National Research Council, Publication 302, 1953.

Cooked Pork Chops, Ham, and Pork Sausage
Nutrients and Calories Provided by 3-Ounce Portions

TABLE I	Protein Gm.	Thiamine mg.	Niacin mg.	Riboflavin mg.	Iron mg.	Phosphorus mg.	Calories
Pork Chops, without bone, cooked, 3 oz.[2]	20	0.71	4.3	0.20	2.6	200	284
Ham, without bone, cooked, 3 oz.[2]	20	0.45	4.0	0.20	2.6	202	338
Pork Sausage, cooked, 3 oz.[3]	14	0.42	2.8	0.20	2.1	139	396

3.5 ounces of fresh pork loin, equivalent to approximately 3 ounces of cooked loin, contains 0.47 mg. pantothenic acid;[4] 0.10 mg. pyridoxine;[4] 0.005 mg. biotin;[5] 36 mg. inositol;[4] 0.08 mg. folic acid;[4] 0.0027 mg. vitamin B_{12};[6] 63 mg. chlorine;[7] 0.1 mg. copper;[7] 20 mg. magnesium;[7] 280 mg. potassium;[7] 70 mg. sodium;[7] and 0.01 mg. manganese.[7]

TABLE II
Nutrients and Calories of Cooked Pork Chops (3 ounces) Expressed as Percentages of Recommended Daily Dietary Allowances[8]

Percentages of Allowances for:	Protein	Thiamine	Niacin	Riboflavin	Iron	Phosphorus	Calories
Girls, 13-15 years of age; weight, 108 lb.; height, 63 inches.	25%	55%	33%	10%	17%	15%	11%
Women, 25 years of age; weight, 121 lb.; height, 62 inches.	31%	59%	36%	14%	22%	17%	12%
Pregnant Women (3rd trimester)	25%	47%	29%	10%	17%	13%	11%

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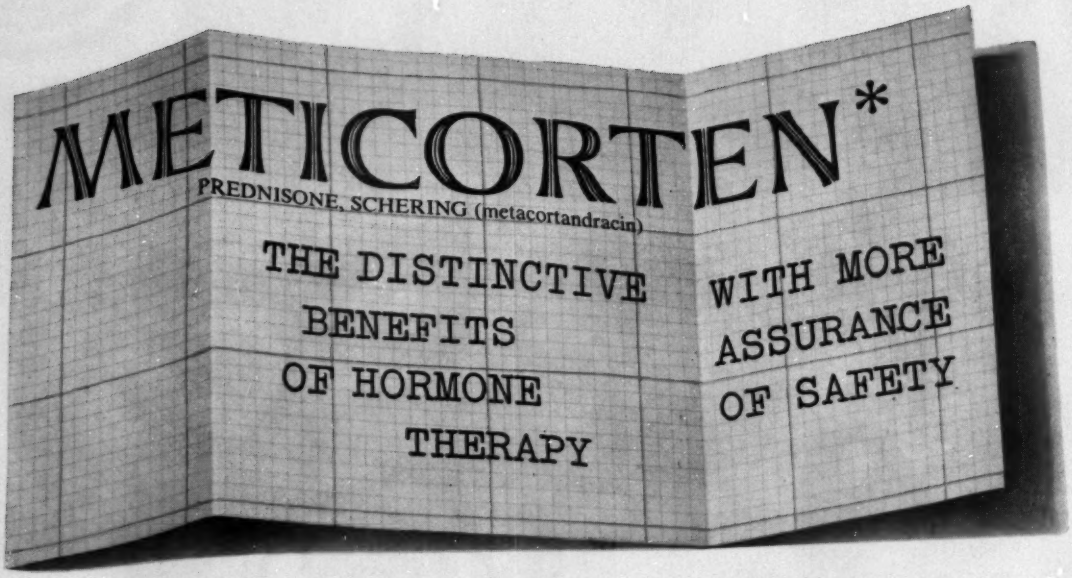

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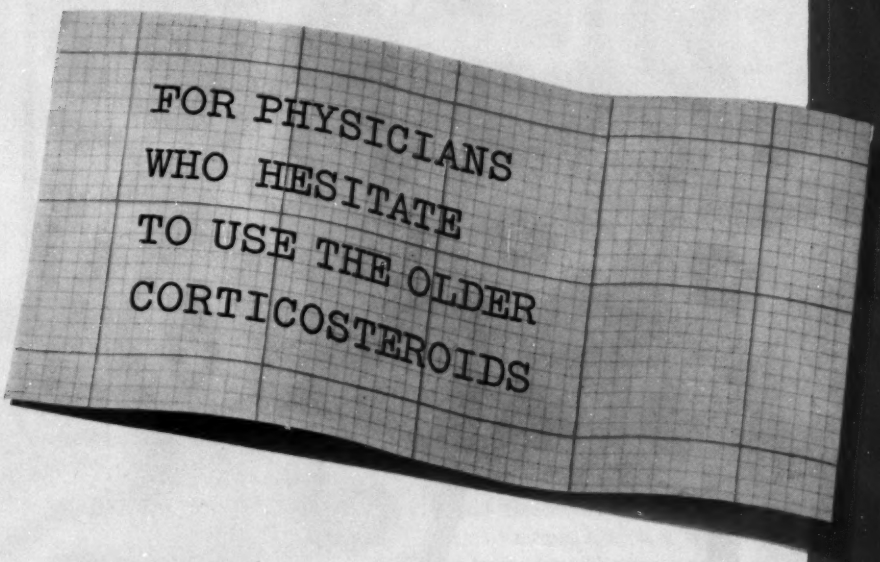

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DIVERTICULA OF THE DUODENUM
With Intrapancreatic Location

EDMUND G. LAIRD, M.D.,*
Wilmington, Del.

The subject of diverticula of the duodenum has been very adequately covered by numerous authors such as Greenler and Curtis[1], Whiting et al[2], Patterson and Bromberg[3], McRoberts[4], and Glasier and Corbett[5], in recent years, not to mention innumerable previous papers on the subject.

The purpose of this report is to discuss the diverticula of the duodenum which lie partially or completely within the substance of the pancreas and briefly to re-emphasize a few facts which are pertinent to these as well as most diverticula of the duodenum.

Up to the present time I have been able to find records of only three specifically reported cases, although McRoberts[4] in 1948 stated as follows: "When the diverticulum is buried in the head of the pancreas, and dissection and excision may prove hazardous, Maclean[6] has advocated opening the duodenum and inverting the sac within it". I assume that the condition is not as rare as it would seem and I imagine that many are seen by x-ray which are considered erroneously to be extrapancreatic and probably are asymptomatic.

It has been estimated by various authors that diverticula of the duodenum cause symptoms in approximately 10% of the cases, while a few estimates as high as 50% have been made. It is my impression that intrapancreatic diverticula of the duodenum cause few, if any, more symptoms than other such diverticula do but that the surgical removal is technically more difficult and is followed by a much greater morbidity.

The symptoms are not pathognomonic and the diagnosis is in nearly all instances made by the x-ray department. The following symptoms can and do occur:

1. Gross bleeding in the intestinal tract.
2. Pain of a vague and intangible nature extending through to the back in the interscapular region.
3. Pain and tenderness above and to either side of the umbilicus, usually the right side.
4. Jaundice due to obstruction of the ampulla of Vater.
5. Vomiting, or obvious duodenal obstruction.
6. Any of the signs and symptoms which may go with inflammation of any diverticulum, anywhere.
7. Bad breath or a bad taste in one's mouth after eating.

As for the major complications, one must mention the following:

1. Hemorrhage.
2. Ulceration and perforation.
3. Obstruction to the biliary and pancreatic ducts.
4. Intestinal obstruction (duodenal).
5. Enterolith formation.

Patterson and Bromberg[3] cite two cases operated on by others in which a Whipple-type pancreatoduodenectomy was performed for inflammatory diverticula of the second portion of the duodenum in the belief that they were carcinomas of the pancreas.

Many symptomatic diverticula of the duodenum have been missed at the first operation because a patient with known gallstones did not have an upper gastro-intestinal x-ray series made before operation. Wherever practicable, a patient who is to be operated on for gallbladder diseases should have a preliminary roentgen ray study of the upper gastro-intestinal tract just as any patient who is to undergo stomach surgery should have a cholecystogram.

As with any other diverticulum of the duodenum, surgery should be attempted

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with extreme caution and only if symptoms are severe. Retention and stasis of food for 6 to 12 hours after eating is often thought to be presumptive evidence that a diverticulum is or might become symptomatic.

When surgery is performed the immediate proximity of the common bile duct and the pancreatic ducts must be kept in mind. The localization of diverticula can be greatly facilitated, as in my own case, by dilating the stomach with air and inflating the duodenum by compressing the stomach manually.

To return to the specific cases of intrapancreatic duodenal diverticula, Patterson and Bromberg[3] reported one arising from the antero-medial aspect of the second portion of the duodenum which was accompanied by ulceration and hemorrhage. Glazier and Corbett[5] described a diverticulum of the third portion of the duodenum made bicornuate by a large vein, the smaller cornu of which penetrated the body of the pancreas. The resection of this was followed by six weeks of pancreatic drainage but with eventual recovery. The follow-up on both cases was of comparatively short duration, as is my own.

Maclean[7] describes a diverticulum of the medial side of the second portion of the duodenum which was very similar to the case which follows. He also approached it trans-duodenally.

CASE REPORT

J. P. D. was admitted to the Delaware Hospital June 14, 1953. He was a fifty-six year old white male who had developed prepandial pains 14 years previously and had lost 20 lbs. in weight. He was treated medically for a peptic ulcer with relief for four years. Four years ago his symptoms recurred and were not relieved by food or medications as previously. The symptoms were manifold and inconsistent, but were described principally as a feeling of "a stoppage of his intestines", usually in the left half of the abdomen. There were no specific food intolerances and in recent months before admission the only relief he obtained was when his stomach was empty. He had not vomited, but had experienced a bad taste in his mouth. There was no pain at night. The patient had changed physicians at frequent intervals for the past 14 years.

Past history was otherwise unremarkable. He had had no jaundice and no abnormal stools. A gastro-intestinal series of x-rays eight months before admission disclosed a large diverticulum of the second portion of the duodenum (Fig. 1) without twenty-four hour retention of barium.

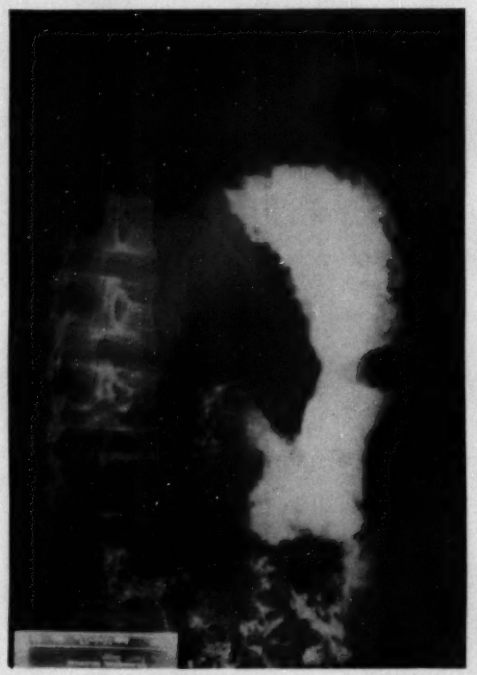

Fig. 1

Physical examination. Pulse 68; blood pressure 150/90; temperature 98°.

The patient was an emaciated, small, slender male with dilated veins over the face and nose which gave him an ashen, cadaverous appearance. His head and neck were unremarkable, as were his lungs, except for a slight emphysema. There were prominent, somewhat dilated veins over the abdomen and thorax. A recent chest x-ray revealed no radiologic evidence of disease. The abdomen was scaphoid, with an almost total absence of subcutaneous fat. Subjective pain without muscle spasm was elicited on palpation in the left lower and left upper quadrants just beneath the rectus abdominis muscle. There was no

epigastric or right upper quadrant tenderness. There were no masses and the liver, kidneys, and spleen were not palpable. Peristalsis was normal. Rectal examination revealed external hemorrhoidal tags.

Laboratory Data. Hgb. 103%; WBC 8,100; differential normal except for 5% eosinophils; Mazzini negative; blood urea nitrogen 11 mg. %; serum albumin 3.9 gms; serum globulin 2.9 gm. %.

Operation. June 16, 1953. An upper right rectus incision was made. The viscera, including the liver, were ptotic. The gallbladder was normal except for some non-inflammatory peritoneal attachments to the duodenum. The stomach and duodenum were unremarkable and the pancreas was soft, flaccid and thin. The remainder of the abdominal cavity was unremarkable. No diverticulum of the duodenum could be found even after completely mobilizing the latter and exploring as far as Treitz's ligament. During the exploration the stomach had gradually become dilated with air, and on compressing it, the pancreas suddenly ballooned up to several times its apparent size. Pressure on the pancreas caused it to collapse again. It could be distended at will by pressure on the stomach. A vertical incision was made in the duodenum and the diverticulum was explored. It measured approximately 3 inches by 1½ inches and had a broad neck. It was approached along the antero-medial aspect of the duodenum by careful dissection and was inverted into the lumen of the duodenum by pulsion and traction. A double ligature of catgut was placed around the inverted neck of a row of 00 black silk mattress sutures was placed with caution through the sero-muscular layers from the outside of the duodenum. The redundant sac was excised and the cuff closed again with a running 000 chromic catgut suture. The duodenum was then closed transversely by a running intestinal chromic catgut suture reinforced by silk mattress sutures. Two cigarette drains were placed in the right lumbar gutter and the abdomen was closed in the usual manner with cotton sutures.

Course. The course postoperatively was uneventful for two days, when he suddenly began to drain clear, golden bile copiously from his wound. After two more days the drainage changed to a clear, thin, colorless material which had all the characteristics of pancreatic secretion and which began to irritate the skin quite markedly. He became distended and suffered crampy pains even though he had daily stools of normal appearance. On June 24 (8th postoperative day), he began to vomit bile-stained material. Wangensteen suction was instituted for several days, after which time the cramps, vomiting, and drainage of pancreatic fluid stopped quite suddenly, and the patient made an uneventful recovery. He was discharged July 7, 1953.

For about one month the patient seemed markedly improved, but gradually all his old symptoms recurred and by August 13 he had already changed his physician twice. It became obvious that he was a definitely psychoneurotic individual. A gastro-intestinal x-ray was taken (Fig. 2) which showed a fixed, but otherwise normal duodenum.

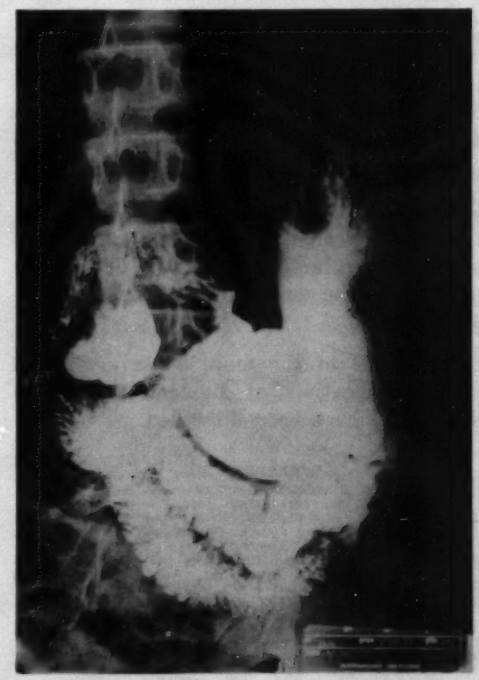

Fig. 2

The patient began to break his appointments and was last seen in a state of panic early one morning complaining that "bones were sticking out of his incision". Examination revealed a normal, well-healed incision.

DISCUSSION

The literature has revealed very few reported cases of diverticula of the duodenum located within the body of the pancreas. I have added one case which, judging from the postoperative results, was presumably asymptomatic and should therefore not have been removed surgically. As far as can be determined from the limited number of cases described, intrapancreatic diverticula cause no more severe symptoms than do other diverticula of the same portion of the duodenum, but the removal of these is much more hazardous. I have presented some of the more acute symptoms and complications occurring at times with diverticula of the duodenum in general, although no effort has been made to discuss the subject of diverticula of the duodenum in its entirety.

SUMMARY

1. Reports of three cases of diverticula of the duodenum situated within the substance or parenchyma of the pancreas have been collected, along with other non-specific references to the existence of the same.

2. A personal case of an intra-pancreatic diverticulum arising from the second portion of the duodenum has been reported in detail.

3. Some of the more acute symptoms and complications of duodenal diverticula in general have been discussed.

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STUDIES ON THE STAPHYLOCOCCUS
II. Nasopharyngeal Carriers

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AND
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That there has been a steady increase in the incidence of antibiotic-resistant staphylococci from hospitalized patients is borne out by the recent medical literature.[1,2,3] In a recent study[4] of culture material from patients at the Delaware Hospital, it was found that 78.6 per cent of strains of pathogenic staphylococci were resistant to penicillin *in vitro*, and 30.5 per cent were resistant to tetracycline.

This high incidence of resistant strains is due in part to the semiclosed environment of a hospital, and also to the cross infection by carriers facilitated by this environment. In 1949 Martin and Whitehead[5] reported the first study of carrier incidences of penicillin-resistant staphylococci. They cultured various body sites, including the skin and nares, and found 31 carriers among 50 healthy males, 19.4 per cent of the strains being penicillin-resistant. Rountree and Thompson[6] tested 200 members of a hospital staff and found a 54.5 per cent carrier rate, 80.7 per cent being penicillin-resistant. By carrying out antibiotic sensitivity testing and bacteriophage typing, Gould and Allan[7] established the fact that staphylococcal infections in hospitalized patients were derived from hospital nasal carriers. These authors suggested that cross infections could be reduced by strict surgical and nursing technique, but recommended specific treatment of the carrier. They obtained a decrease in carrier rate by nasal application of oxytetracycline cream, but three months after discontinuing treatments, the carrier rate was at its previous level.

The purpose of this study was to determine and compare the naso-pharyngeal carrier rate of staphylococci in the following groups:

1. Nursing personnel in direct contact with patients at the Delaware Hospital.
2. Hospital personnel with no *patient* contact.

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TABLE 1

NASOPHARYNGEAL CARRIER RATE & ANTIBIOTIC SENSITIVITY OF STAPH. AUREUS

Source	% Showing Positive Isolations	% Penicillin Resistant	% Tetracycline Resistant	% Erythromycin Resistant	% Chloramphenicol Resistant
Nurses	32%	87.5%	18.8%	0	6.3%
Hospital Personnel	30%	46.6%	0	0	0
Controls	20%	30%	20%	0	0

3. Industrial personnel with no *hospital* contact.

METHOD

Nasopharyngeal swabs were obtained by using cotton-tipped, 24 gauge nichrome wire, and these were promptly inoculated to blood agar plates and thioglycollate medium. These were incubated 18 to 24 hours at 37°C. If the original plate showed no growth, one loopful of the thioglycollate culture was inoculated to a second blood agar plate, and incubated as before. Growth of *Staph. aureus* on either medium was considered a positive culture. Sensitivity testing was carried out on all isolated strains by subculture and antibiotic discs, including penicillin, tetracycline, erythromycin and chloramphenicol. Coagulase tests were carried out on all strains isolated.

RESULTS

Thirty-two per cent of 50 nurses and 30 per cent of 50 hospital employees with no patient contact showed positive cultures for *Staph. aureus*. Twenty per cent of the 50 industrial personnel showed positive cultures for *Staph. aureus*. These differences in carrier rate are not statistically significant. The significant difference, however, appears in the penicillin resistance of the strains isolated from these three groups. Eighty-seven per cent of the *Staph, aureus* from the nurses were penicillin-resistant, while 46.6 per cent of the strains from non-patient contact hospital personnel were resistant to this antibiotic. Only 30 per cent of the strains from industrial employees were penicillin-resistant. On subjecting these figures to statistical analysis, the difference is significant between nurses and other hospital personnel ($chi^2 = 4.2$), and even more significant between nurses and industrial personnel ($chi^2 = 6.6$).

Relatively few strains were encountered that were resistant to the other antibiotics.

DISCUSSION

Nine cases of post-operative wound infection due to coagulase-positive, penicillin-resistant *Staph. aureus* were observed in the surgical wards of the Delaware Hospital during a three month period. The present study would suggest a casual relationship to the carrier state of the nursing personnel. Further studies are definitely indicated on the following: isolation of patients with staphylococcal infection; careful supervision of nurse transfer from one ward to another; the oiling of bedclothes; and eradication of the carrier state.

SUMMARY

1. Studies on the nasopharyngeal carrier rate of *Staph. aureus* in hospital patient and non-patient contact personnel are reported.

2. The antibiotic sensitivity of the strains isolated indicate a significant increase in penicillin-resistant *Staph. aureus* among the nursing personnel.

3. The significance of these findings are discussed.

The authors gratefully acknowledge the technical assistance of Mrs. Jeannette Shannon.

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STUDIES ON THE STAPHYLOCOCCUS
III. Penicillinase Production

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and
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The isolation of penicillin-resistant staphylococci resulted in investigations by Abraham and Chain,[1] resulting in the identification of an enzyme, penicillinase, which inactivated penicillin.

Early studies[2] on penicillinase demonstrated its presence in only naturally-occuring, penicillin-resistant staphylococci, and not those strains made resistant *in vitro* or *in vivo*. Other resistant microorganisms, such as shigella, produce penicillinase; and likewise, many other bacteria resistant to penicillin do not elaborate the enzyme. The close correlation between penicillinase production and penicillin-resistance of staphylococci, however, suggests a cause and effect relationship. Bondi[2] demonstrated that staphylococci requiring more than 0.15 units per ml. of penicillin for inhibition produce penicillinase in detectable amounts.

The production of penicillinase by the resistant strains of staphylococcus has important implications in the clinical and laboratory studies of this organism. Therefore, we thought it necessary to perfect a method for determining penicillinase production which would be amenable to the time and equipment available in our laboratory.

METHOD

In 1952 El Ghoroury[3] reported a simple method for the determination of penicillinase production, which correlated satisfactorily with the cup method of Bondi and Dietz. A dry blood agar plate was streaked with a known penicillin sensitive strain of *Staph. aureus*, and filter paper discs saturated with a solution of penicillin containing 15 units per ml. were placed on the surface of this plate. One disc served as a control, while the other discs were inoculated with a loopful of a 24 hour broth culture of the strains to be tested for penicillinase production. A zone of growth inhibition of more than 20 mm. in diameter occurred around the control disc, while the discs inoculated with a penicillin-resistant *Staph. aureus* showed little or no inhibitory zone. This was due presumably to the destruction or inactivation of penicillin by the penicillinase. On repeated trials, the authors were unable to reproduce El Ghoroury's results. Bondi[4] suggested that since staphylococcus penicillinase is an intracellular enzyme, this method may not allow for adequate amounts of the enzyme to be released from the bacterial cells. He, therefore, recommended a modification of El Ghoroury's technique, which proved satisfactory in this study.

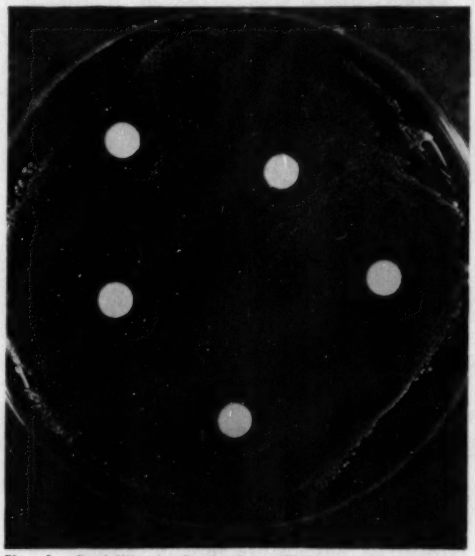

Fig. 1. Penicillinase Production. Right—positive strains. Upper left—penicillin control. Lower left—negative strain.

The strains to be tested were grown for 18 hours at 37°C., in Difco tryptose phosphate broth, following which sufficient penicillin was added to give a final concentration of 15 units per ml. These tubes were then incubated at 37°C. for 20 to 30 minutes. Filter paper discs were then dipped in this mixture and placed on blood agar plates previously streaked with a penicillin-sensitive *Staph. aureus*, inhibited by 0.031 units per ml., a control disc containing only penicillin (15 units per ml.) being included on each plate. After 18 to 24 hours incubation, the plates were examined for inhibition zones, and failure to show such zones was interpreted as indicating penicillinase production.

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TABLE I

PENICILLINASE PRODUCTION OF STAPHYLOCOCCI

Organism	Number of Strains	Penicillinase Produced	No Penicillinase Produced
Staph. aureus (Penicillin-resistant)	40	40	0
Staph. aureus (Penicillin-sensitive)	27	0	27
Staph. albus (Penicillin-resistant)	35	35	0

Forty strains of coagulase-positive, penicillin-resistant *Staph. aureus* and 35 strains of coagulase-negative, penicillin-resistant *Staph. albus* were tested by this method. All of the 75 strains of penicillin-resistant staphylococci demonstrated penicillinase production. Twenty-seven control strains of penicillin-sensitive *Staph. aureus* produced no penicillinase.

SUMMARY

1. A modified technique for the testing of penicillinase production of penicillin-resistant staphylococci is described.
2. By this technique, 75 strains of penicillin-resistant *Staph. aureus* and *Staph. albus* were shown to produce penicillinase.
3. Twenty-seven control strains of penicillin-sensitive *Staph. aureus* produced no penicillinase.

The authors gratefully acknowledge the technical assistance of Mrs. Jeanette Shannon.

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TREATMENT OF EPITHELIOMA BY MODIFIED SHERWELL TECHNIQUE*

A Review of 271 Cases

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Many modalities for the treatment of cutaneous cancer are available and in use today. The essential requirement of each is the complete destruction of all cancer tissue. These include surgical excision, irradiation, cautery and fulgeration, cancer pastes, podophyllum, zinc chloride fixation, and surgical removal.

S. Sherwell, writing in the *Journal of Cutaneous Diseases*, in 1910, described a procedure for the treatment of cutaneous malignancies under the title: "Further Observations on the Technique of an Efficient Procedure for the Removal and Cure of Superficial Malignant Growths." This article was read and its mode of treatment adopted by many dermatologists, and has continued to be popular as an office procedure for the removal of epitheliomas.

The technique of the Sherwell operation is as follows: Adequate local anesthesia is obtained by drugs such as procaine hydrochloride injected subcutaneously around and beneath the tumor mass. Following this a biopsy specimen may be obtained. The entire area is then subjected to vigorous curettage, resulting in the removal of all gross malignant tissue and leaving a shallow depressed ulcer with firm base and border. Next a solution of acid nitrate of mercury is applied to the wound with a cotton pledget. A superficial eschar forms, with complete control of bleeding. Afterwards, the acid nitrate of mercury is neutralized with bicarbonate of soda. A modification of this technique consists in the substitution of fulgeration and repeated curettage for the acid nitrate of mercury application and subsequent neutralization. Finally, the curetted area and a suitable border of normal skin is subjected to a single dose of superficial, unfiltered x-ray. This modified procedure has been used in my office practice for the past 20 years.

In 1953 a critical survey of all private epithelioma cases treated by this method was undertaken, and all cases available in my files form the material for this study. No cases of cancer of the lip, buccal mucosa, eyelid or genitalia are included in this series, as they have not been treated by this method. Malignant melanomas are likewise excluded.

* Read before the Delaware Hospital Tumor Clinic.
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The various findings are listed in the following tables:

TABLE 1

Total Cases	Recurrences	Percentage
271	12	4.4
Total One Year Follow-up 185	12	6.48
Total Biopsies, One Year Follow-up 116	6	5.1

Basal	Squamous	Mixed	Sclerosing	Trichoepithelioma
83	22	9	1	1
71.5%	18.9%	7.7%	0.45%	0.45%

TABLE 2
Recurrences — Other Authors

Sharp, G. S. and Blinkley, F. D.	Allen, K. D. A. and Freed, J. H.	Lamb, J. H.	Mohs, F. E.
11%	3.2%	2%	6.4%

TABLE 3
Recurrent Cases — Author's

	Type	Disposition	Remarks
J. D.	——	Retreated	3 Year Cure
M. H.	Basal Multiple	Surgery	
J. B. J.	Basal	Retreated	Ultimate Cure
F. M.	——	X-ray	
L. N. P.	——	Radium	
J. F. R.	Sclerosing Basal	Retreated	1 Year Cure at Time of Cardiac Death
C. R.	Basal	Cancer Clinic	Excision and Cure
K. R.		Retreated	8 Month Cure: Probable Recurrence
J. R.	Basal	——	
F. B.	——	Retreated	No Data
F. E.	Basal	Cancer Clinic	Excision and Cure
J. F. H.	——	Surgery	Excision and Cure

There were no complications. No deaths occurred. No metastases occurred. No radio dermatitis sequellae have been observed. No scars required plastic repair.

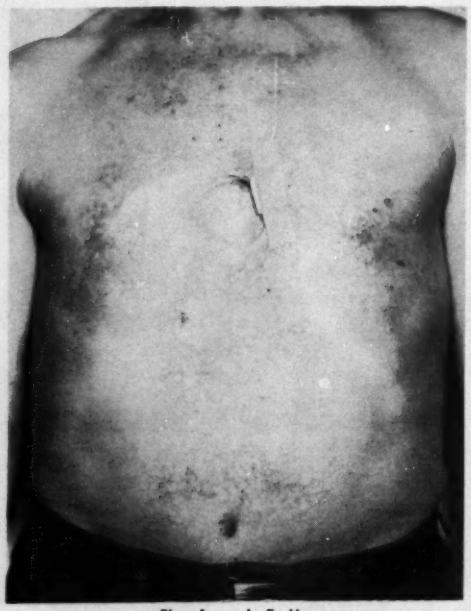

Fig. 1. — J. F. H.

One of the recurrent cases J. F. H., a robust male, aged 70 is reported in brief, because of its unusual nature. Broad bands of severe chronic radiodermatitis form a large cross on chest and upper abdomen, the result of application of radio active plasters 30 years ago. Telangiectasia and atrophy are marked. Epithelioma developed in 1945 and was destroyed by radical curettage and fulgeration. Four more lesions have developed and have been removed in similar manner, in an eight year period, 1945-1953. One of these recurred and has been cured with radical surgical excision and plastic repair. Patient has declined to have extensive plastic surgery of entire area.

SUMMARY

A follow-up survey of 271 cases of epitheliomas treated by a modified Sherwell technique, consisting of repeated curettage, fulgeration and single dose of x-ray, was made. There were 12 recurrences, (6.48%) among the 185 cases in which a follow-up of one year or longer could be obtained. There were no complications. One case, with recurrent epithelioma in chronic radio dermatitis of unusual origin, is reported in brief detail.

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DR. WITNESS*

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When I was invited to attend this dinner meeting and to talk about "The Court and the Doctor", I was happy to accept the invitation. I think that the subject deserves discussion and consideration by our two professions to the end that mutual understanding and cooperation may be promoted.

We start with the premise that a physician rarely enjoys appearing in court as a witness. Perhaps, that is an understatement. Perhaps, a more precise way of expressing it would be to say that most doctors would rather take a beating. I have given some thought to this deplorable sit-

* Address delivered before the New Castle County Medical Society, June 21, 1955.
** Judge of the Superior Court of Delaware.

uation and I have talked to men in both professions about it. There appear to be several basic reasons for this rather unneighborly attitude of medical men toward courts and lawyers. It may be that a recognition of some of the reasons for the aversion may help us to diagnose the case and commence treatment.

At the outset, we must realize that the doctor is an individualist, accustomed to making decisions and accustomed to being obeyed. He makes his findings and prescribes the future conduct of his patient with only occasional argument or contradiction and, quite unreasonably but humanly enough, the doctor is apt to resent a challenge to his pronouncements.

Put this into legal phraseology and it means that the doctor usually acts as judge and jury in the cases that come under his care. As jury, he determines the particular transgression of the laws of health of which his patient has, consciously or unconsciously, been guilty; and, as judge, he prescribes the penalty, the nauseous potion or the surgical ordeal by which the offender may expiate his offense and rejoin the ranks of the hygienically sinless. It is quite understandable, therefore, why the physician is often resentful when his professional judgment is challenged in the trial of a law suit in which he appears as a witness.

Another reason becomes apparent for the doctor's aversion to the courtroom. There is a fundamental difference in the method of approach of law and medicine toward the discovery of truth. The lawyer attempts to maintain his position, which he believes to be the truth, by argument and contention with opposing counsel. Without differences of opinion much of the work of the legal profession would disappear. The physician, on the other hand, does not live by contention and controversy. His training and practice are in the clinical atmosphere of the laboratory and the hospital. He demands full exploration of the case history and friendly discussion of all phases of a case. When all pertinent data are collected he correlates them and forms a judgment.

And so, by training and practice, the whole tempo of the day-to-day experience of the physician and the lawyer are totally different. Is it any wonder, then, that the physician is reluctant to step out of an atmosphere in which he is at home and into an atmosphere of controversy to which he is not accustomed, an atmosphere which irritates him and in which he feels suddenly like Exhibit A with all eyes upon him? Often, mere unfamiliarity is sufficient to breed suspicion.

In addition to being unfamiliar with, and uncomfortable in, situations which are commonplace to a lawyer, physicians complain that too often they are practically made parties to the case in which they testify. We are all aware of this problem. We know that some clients and some patients are not looking for legal counsel or medical advice at all. They are looking for confederates! Fortunately, this type of harassment is infrequent.

My advice to doctors is to refuse to become advocates in any sense of the word. On occasion, I have detected in doctors on the witness stand a temptation to become an advocate which must be resisted. That temptation arises not only because of the prodding of lawyers but also because of the doctor's personal association with the patient-client. Then, too, the doctor's sympathies are often aroused; and sometimes when his opinions are challenged, he is inclined to overstate in order to emphasize a point. The medical witness who becomes an advocate invariably finds himself subject to a more vigorous attack under cross-examination and, as his role of advocate becomes more apparent, the Court, the jury and counsel lose confidence in his testimony as a physician. I think doctors are well advised, always, to leave advocacy to the lawyers.

I think that another reason for the doctor's reluctance to be a witness is his failure to understand fully the concept of examination and cross-examination. When the average medical witness takes the witness stand and has sworn to tell the truth, the whole truth, and nothing but the truth, he seems to be under the general impression that, while one attorney is doing his level best to bring out the truth, the lawyer

on the other side is trying equally hard to keep the truth from being brought out.

Our system of trying a case is the adversary system. Consequently, any doctor giving testimony inevitably finds himself cast in the role of either a plaintiff's witness or a defendant's witness. Try as he might to be absolutely impartial, he finds himself constantly pulled and hauled toward one or the other of the contending camps by opposing counsel. You must understand that, in our adversary system, next to his duty as an officer of the Court and as a man of honor, a lawyer's duty is to win his client's case. The lawyer knows that in personal injury actions, for example, the medical side of his case must be established through the medium of doctors. Quite naturally, he is going to emphasize and play up those aspects of his client's case that will best serve his purpose and tend towards the verdict he seeks. Indeed, if he failed to do so, he would be remiss in his duties.

The discovery of truth, after all, is the sole objective of a trial. The discovery of truth is the only means by which justice can be done and both of our professions are mutually interested in that end. After centuries of experience, the Anglo-American method of seeking truth by examination and cross-examination has not been excelled by any other method known to man. A better understanding of the concept of examination and cross-examination would be helpful to every medical witness I have ever encountered.

Another reason for the doctor's aversion to the courtroom is his dislike for the loss of time that a court appearance means. Everyone knows that our doctors are busy and that their time should not be wasted. The Court is always concerned about this matter of wasting time of medical witnesses and I can assure you that if the lawyer who is calling you to the witness stand wishes to be considerate, he can usually plan the timing of his case and make the necessary arrangements with the Court to have you put on at a designated time or on short notice. If this is not done the next time you are subpoenaed, demand it of counsel. It is your privilege and I think you will find that the Court will support your demand, even though you be under subpoena to attend the Court generally.

Now, since lawsuits and lawyers cause so much distress among members of your profession, perhaps, as a representative of my profession, I may make amends somewhat by a few suggestions, based upon my observations as a trial judge, as to how best to meet this ordeal from which cool and courageous physicians, men who face and battle death daily with equanimity, seem to shrink.

I think the primary thing every physician should remember, as he enters the portals of the courtroom, is that he is revered and respected by every person in that courtroom because he is a doctor of medicine. If that reverence and respect are in any way lessened before the physician leaves the courtroom, it can only be the fault of the physician himself.

I suggest to every doctor that adequate preparation for the trial is the complete answer. No lawyer, no matter how versatile he may be nor how much he may have crammed, can possibly be as well prepared as, or a match for, the physician if he too is prepared for the examination. The administration of justice and the physician's duty to his patient require that the doctor come into the courtroom knowing more about his patient and his patient's condition than any other person there. If a doctor does this he will not have an unpleasant experience on the witness stand nor will he be humiliated in the courtroom. It is only the unprepared medical witness who can be made to look foolish by a lawyer when the subject matter, after all, is within the witness' chosen profession.

Preparation for examination at the trial includes consultation with the lawyer who calls the physician as a witness in the case. It should be remembered that a witness is not called to make a speech. He can testify only in response to questions. For most of us, that is a very unusual way of expressing ourselves. Yet we know, after centuries of experience, that it is the best way by which evidence may be adduced. To prepare for this unusual method of presentation, doctors should insist upon an inter-

view with counsel before testifying. The lawyer, I am certain, will always welcome a pretrial conference.

Now, of course, it is cross-examination by opposing counsel that the physician finds most objectionable in his courtroom role. It is usually cross-examination that leads to discomfiture to the unprepared witness. Your testimony on direct examination may show such preparation and may carry conviction to such a degree that the lawyer on the other side asks no questions at all. As a rule, however, counsel with the duty of cross-examination may attempt several things:

The cross-examiner may try to discredit the value of your testimony as an expert. Your opinion may differ from that of the writer of a textbook. It has been said that all textbooks are out of date by the time they are published, but there seems to be an aura of authority surrounding the printed page. The good medical witness never hesitates to differ with the textbook writer if he can give good reasons for his opinion. If he is prepared and has anticipated the question, he may even be prepared with another textbook to support his view.

Sometimes you will be faced with the general statement of the cross-examiner that it is only human to make mistakes, and after all, Doctor, you are not superhuman, are you? If you get the chance, your best reply, I think, is that you have considered the various other possibilities, rejected them, and chosen the one you have put forward. To do this successfully means that you must be prepared to give reasons for your belief, and that again implies meticulous preparation.

At times the cross-examiner will attempt to discredit your opinion by comparing it with the opinion of some other local physician. Sometimes you will be told "Dr. — this morning, Dr. XY said thus and so; do you think he is wrong?" In reply to this type of approach by the cross-examiner one may simply say that one can only accept responsibility for one's own opinions and beg to be excused from commenting on the opinions of another doctor. This demurrer will generally close the subject and it will have the Court's understanding and support.

There are two questions, sometimes heard during cross-examination, which are considered unfair and reprehensible. I have watched these questions cause consternation on the part of the inexperienced medical witness.

One question goes like this: "Doctor, isn't it true that you have agreed to accept a fee for your appearance and testimony here today?" The inexperienced medical witness is often not quite certain how an admission of payment is going to be taken by the Court and jury. Of course, there is nothing improper about a reasonable fee for the expert witness and it is considered unfair of counsel to attempt to imply otherwise to the jury by asking the question.

The other question which often causes undue concern is this one: "Is it, or is it not true, Doctor, that you discussed your testimony with the lawyer on your side of this case just before Court opened this morning?" Again, there is the implication to the jury that a physician does something wrong by discussing the case with counsel. These are unfair tactics and I have taken the occasion to caution counsel about this practice when it has occurred in any case before me. A medical witness should never let either of these two questions cause him to become disconcerted.

There are certain pet questions favored by the expert cross-examiner which are of the "when did you lick your wife last" category. For example, the doctor may be questioned as to his relationship or friendship with the party or his attorney. He may be asked whether he was subpoenaed for appearance in Court. If not subpoenaed, that indicates close friendship with the party or his attorney. On the other hand, if the doctor was subpoenaed, that indicates lack of confidence in the doctor or that the medical bill has not been paid; and if the bill has not been paid, that indicates bias and interest in the outcome of the proceeding. Under this type of attack, the witness is completely at the mercy of the examiner. The witness must not feel too frustrated, however, and must rely on

counsel to clear away all debris in his redirect examination or upon summation to the jury.

The cross-examining attorney must never be looked upon by the doctor as an opponent with whom to match wits. The doctor is not on an equal footing because he has different ground rules. You are not permitted to argue with counsel. You can only answer his questions. The important thing is to avoid becoming flustered or angry. I have often seen a medical witness make a good impression through a long examination only to destroy it in the last few seconds by losing his temper at what he considers to be some inane question or personal affront.

The medical witness must keep in mind at all times the first reason for his being in Court at all. It is to enlighten the judge and the jury on the facts of the case. His prime duty, therefore, is to make use of the simplest possible language to express his thoughts. All medical men have a technical vocabulary they use as a means of communication among themselves. The judge and the jury lack this equipment.

The doctor should therefore see to it that judge and jury both understand what he has to say. He must use terms a layman can understand. In the courtroom, the "thigh bone" or the "arm bone" is better than "femur" or "humerus", "wrist" is better than "carpus" and "spine" is better than "vertebral column". The choice of the words of the layman is apt to go against the grain, I know, for there is a loss of precision. Some loss of precision, however, is preferable to a state of things where, though precision may have its place in your mind, the judge or jury has been left in a condition of hopeless confusion.

It is important for the expert witness to remember that he is not presenting a scientific paper. He is trying to convey the truth to someone else, who is desperately anxious to learn the truth. Sometimes the judge may call for amplification of some statement you have made. The interruption should be welcomed, and, even to the learned judge, the simplest possible phrases should be used.

I cannot give you a complete description of the good witness. Generally speaking, the forthright individual who speaks clearly, simply and briefly and answers only the questions asked of him makes by far the best impression. Truth, simplicity, brevity, candor, these are the cardinal virtues of the good witness. The good medical witness, in my opinion, also knows how to say: "I do not know".

But above all, the good medical witness speaks in every-day language. I have seen juries sit up expectantly when a doctor is called to the witness box and then gradually lose interest as he proceeds to describe the case in technical language. He might as well have been speaking in a foreign language. Not only is the attention of the jury lost, but the captive audience, the judge and jury, cannot help but become irritated by being asked to listen to what they cannot understand.

And so, although we "rib" each other on the subject, everyone will agree, I think, that the two professions have mutual problems which should be seriously considered for the sake of the improvement of the administration of justice. There should be brought to the physician an awareness and understanding of the many situations in which the paths of law and medicine cross and an appreciation of the methods by which the law approaches these situations. It is apparently human nature to fear and distrust that which is not thoroughly understood. To the extent, therefore, that physicians understand the general purposes and goals of the lawyer's technique they lose their fear and distrust of legal situations and become more cooperative. This is equally true so far as lawyers and an understanding of the techniques of science are concerned.

We cannot do very much in the field of education, although there does seem to be some improvement in the curricula of the medical schools and the law schools along these lines. We can, however, work toward improvement on the local level by closer association of the Medical Society of Delaware and the Delaware Bar Association. A joint meeting of the two organizations occasionally, or a joint standing committee, or

a seminar once a year, any of these should be gratifying to both professions and beneficial to the public. The theme of such programing could well be: "Let us understand each other."

To the extent that understanding overcomes the doctor's traditional fear of the courtroom and enables him to appreciate the lawyer's problems, to that extent the doctor may be more receptive to the lawyer's request for assistance in the search for truth. To the extent that the attorney, by understanding, becomes aware of the physician's problems, to that extent he will be able to deal with the physician more tactfully and with better chance of success.

I hope that our two groups may draw together in the interest of the administration of justice.

THE MONTH IN WASHINGTON

Washington, D. C.—The second session of the eighty-fourth Congress is under way, and in medical legislation—as in all other fields—this promises to be much livelier than last year's deliberations.

For one thing, neither the Republican administration nor the Democratic party, which is in control on Capitol Hill, got anywhere near as much as it wanted last year in medical legislation.

For another thing, and something that shouldn't be lost sight of at any time, both parties this year will be legislating with one eye cocked toward next November, when the voters make a choice between the two parties. Try as they might to pass laws for the good of all the people, neither party can afford to ignore the political realities of the situation: each will want to take credit for any legislation with popular appeal or where that is impossible, at least to see that the other party doesn't get the credit.

In front of this political mosaic, these are some of the medically-important issues that will be fought out in Senate and House:

1. Federal guarantee of mortgages on health facilities. This has been on the Congressional calendar for two years; it was pushed hard in 1954, and was given some consideration in 1955. It would mean that the federal government would underwrite mortgages for hospitals, clinics and nursing homes, under certain conditions, thereby allowing some sponsors to obtain loans they couldn't otherwise get, or to obtain them on longer terms and with lower interest.

2. Federal grants for research facilities. Under this plan—approved last session by the Senate—the U.S. would make outright grants to laboratories, medical schools and clinics for building facilities for research in specific diseases, such as cancer and heart disease.

3. Federal aid to medical education. This perennial project probably is closer to Congressional enactment now than ever before. The most popular bill is one restricting the federal role to grants for building and equipment, with a financial incentive held out to those schools willing to increase their enrollment. This bill may be tied in with some other grants bill, such as the one for research.

4. Salk vaccine. Legislation authorizing federal appropriations for the purchase of Salk poliomyelitis vaccine ($30 million for the current year) expires February 15, virtually insuring Congressional action of some sort before that date. One issue is whether the federal government should continue the grants; more controversial is the question of whether the U.S. should move in to control the allocation and distribution of the vaccine. Allocation and distribution now are handled under a voluntary program supervised by the U.S. Public Health Service.

5. Increases in federal appropriations for medical research. Over the last few years—since the National Institutes of Health came of age—Congress repeatedly has increased research grants over the amounts the Budget Bureau allowed Public Health Service to request. Indications are that this year the Budget Bureau may have to give way and allow important increases to be requested of Congress. Congress probably would want to add on its own special additions anyway, resulting in more money than ever before available for work on cancer, heart disease, mental illness, arthritis, blindness and the many other conditions.

6. OASI-covered persons could receive payments beginning at age 50 if determined to be disabled. Under present law retire-

ment payments for all are available at age 65. The bill containing this provision (H.R. 7225) passed the House last session by an overwhelming margin. It is now before the Senate Finance Committee, where the next phase of the legislative contest will be fought out in 1956.

The lop-sided House vote on disability payments may be discounted in part because of the parliamentary maneuvering by sponsors of the legislation. House members had only 40 minutes to debate this bill, and no opportunity to amend it. It was a case of accepting the whole bill—which contains a number of other social security liberalizations not of medical significance—or being politically damned as opposed to social security per se.

The American Medical Association maintains that the present expanding rehabilitation programs would be undermined by cash payments for disability, that the financial and other long-range aspects of the disability payments plan have not been thoroughly studied, and that the machinery for disability payments would inevitably project the federal government deeply into the medical care picture.

POLIO AHEAD

Delaware will still have polio problems in 1956. The Salk vaccine is a major weapon against paralytic poliomyelitis, but it has not yet won the war against this disease.

Continuing cooperation of physicians must be had both in administering the vaccine and in caring for patients already paralyzed and *who will be* paralyzed in spite of the vaccine. The Salk vaccine is not 100% effective and it will take considerable time yet, perhaps years, before all individuals most susceptible to paralytic poliomyelitis can be fully immunized against it.

The National Foundation for Infantile Paralysis, supported solely through public contributions to its January March of Dimes, has made an enviable record, both in this state and nationwide, for meeting the problems posed by paralytic polio. In 1955 the March of Dimes gave 44,000 cc. of Salk vaccine without charge to the state of Delaware to initiate a statewide vaccination program.

The results already reported from the use of the vaccine are most encouraging but they must not be allowed to blind the eye of the medical profession to the road that still lies ahead. There remains a great need for additional research to improve the Salk vaccine, to determine the duration of immunity it effects (and conversely to determine the need for "booster shots") and to provide the best possible treatment for patients already or yet to be involved with paralytic poliomyelitis. There is also a vast need for the professional education of young men and women who will contribute to the necessary research and help give the needed treatment.

To pay for research, education, and aid to polio patients the March of Dimes needs $47,600,000 in 1956. Delaware physicians, knowing both the need and the record, will want to support and urge their patients to support the 1956 March of Dimes in their own communities.

A brief review of the record of the National Foundation for Infantile Paralysis in Delaware, where it has three local chapters, should help to orient physicians to the many services to patients and the professions which have been made possible by the March of Dimes since 1938, when the National Foundation was founded.

Over $310,000 has been spent in Delaware by local chapters for the care of polio patients.

A total of 12 National Foundation scholarships and fellowships have been awarded to Delaware residents.

The diagnosis of active pulmonary tuberculosis is not a simple decision and may be equally troublesome for the family physician and for the medical specialist. This is true when tuberculosis is the only disease to be considered. How much more perplexing is the problem when the disease occurs in the course of other long-term illnesses. Abraham Gelperin, M.D., Dr. P. H., Leon J. Galinsky, M.D., and Albert P. Iskrant, M.D., Pub. Health Rep., August, 1955.

Editorials

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VOL. 28 JANUARY, 1956 NO. 1

OUR NEW ASSISTANT "EX SEC"

The House of Delegates of the Medical Society of Delaware at its 1955 meeting voted to engage a full-time assistant for the present executive secretary, who has functioned for the past eight years on a part-time basis. The House expressed a preference for a Delaware layman, who could manage its public and legislative relations, together with other duties, rather than somebody from another state who would have to learn the Delaware picture de novo. The Council has secured the services of such an individual who, though young and of limited experience in some fields, gives great promise for the future.

The new appointee, whose appointment becomes effective on February 1st is Mr. Lawrence C. Morris, Jr., whose home is at 1301 N. Jackson Street, Wilmington. Mr. Morris graduated from Tower Hill School, and received his bachelor's degree from Haverford College in 1953, where he was in the top one-fourth of his class. Mr. Morris has had experience in the fields of radio, advertising, and public relations. His personality is most pleasing and he has the ability to make friends quickly. He is an Episcopalian, and unmarried.

We feel sure that Mr. Morris will become a real asset to our Society. It behooves every officer and every member to give him the fullest cooperation and support.

A TACTICAL BLUNDER

It has often been said that a Society is as good as its secretary. With this statement we fully agree. But a good secretary becomes a better secretary—with added experience. In recent years the Kent and Sussex County Medical Societies have been in the habit of changing their secretaries almost every year. This we believe to be a tactical blunder. Generally it takes more than one year for the man to learn what reports are to be made, and when and where to make them; what elections are to be held, and when; and many other items that make for the efficient management of his office. After a few years the work is no longer a burden but a mere routine.

From 1901 to 1955, inclusive, the New Castle County Medical Society has had eighteen secretaries, or an average tenure of three years. In that half century there was one secretary who served ten years, another six years, and two others five years each. Subtracting these four men and their twenty-six years, we have left twenty-nine years for fourteen men—an average of two years.

In the Medical Society of Delaware there was one fifty year period during which only three secretaries served—seventeen years each! While we are not expecting to have many such seventeen year men these hectic days, we do sincerely hope we can return to the tenures of five, six, or even ten years. It would be a very good thing for the County Societies, and a better thing for the State Society and the A.M.A. Let's do it!

A.M.A. HOUSE OF DELEGATES NOV. 29 - DEC. 2, 1955

Boston, Mass., Dec. 2 — Social security, the report of the Committee on Medical Practices, grievance committees and revisions of the code of medical ethics were among the major subjects of discussion and action by the House of Delegates at the American Medical Association's Ninth Clinical Meeting held Nov. 29 - Dec. 2 in Boston.

Named as the 1955 General Practitioner of the Year was Dr. E. Roger Samuel of Mount Carmel, Pa., whose selection by a special committee of the Board of Trustees was announced at the opening session on Tuesday. Dr. Samuel, a former member of the House of Delegates and a general practitioner for 35 years, received the medal and citation presented annually for community service by a family doctor.

Dr. Gunnar Gundersen, A.M.A. Board Chairman, who made the award to Dr. Samuel, also presented a special citation to Dr. Torald Sollmann of Cleveland, Ohio, charter member of the A.M.A. Council on Pharmacy and Chemistry for over 50 years and its chairman since 1936. Dr. Sollmann, 81 years old, was honored for his "outstanding service to the medical profession and on behalf of the advancement of medical science."

Total registration at the end of the third day of the meeting had reached 7,027, including 3,672 physicians.

Social Security

Major legislative policy action taken at the Boston meeting involved H.R. 7225, known as the Social Security Amendments of 1955. This bill, which was passed last summer by the U. S. House of Representatives and is now pending before the Senate Finance Committee, includes a proposal for federal cash benefits to selected individuals judged to be permanently and totally disabled. The House of Delegates adopted a substitute resolution proposed by the Reference Committee on Legislation and Public Relations to combine the intent of four resolutions and three supplementary reports of the Board of Trustees dealing with H.R. 7225 and other aspects of Social Security. The substitute resolution stated the following policy:

"That the American Medical Association reiterate in the strongest possible terms its determination to resist any encroachment upon the American system of medical practice which would be detrimental to our patients, the American people;

"That the American Medical Association urge and support the creation of a well-qualified commission, either governmental or private or both, to make a thorough, objective and impartial study of the economic, social and political impact of Social Security, both medical and otherwise, and that the facts developed by such a study should be the sole basis for objective non-political improvements to the Social Security Act, for the benefit of all the American people;

"That the American Medical Association pledges its wholehearted cooperation in such a study of Social Security in the United States, and will devote its best efforts to procuring and providing full information on the medical aspects of disability, rehabilitation and medical care of the disabled, and

"That copies of this resolution be transmitted to the President of the United States, to all members of the Cabinet, to all members of the Congress, and to all constituent state medical associations."

OASI Coverage of Physicians

In another action on social security, the House Passed the following resolution designed to determine the exact attitude of physicians toward compulsory or voluntary coverage under the social security system:

"Whereas, Misunderstanding exists about the position of the medical profession on the question of the inclusion of physicians in the Old Age and Survivors Insurance provisions of the Social Security Act; therefore be it

"Resolved, That the House of Delagates of the American Medical Association recommend to state societies that they poll their entire membership on this question and that the results of the poll be transmitted to the Board of Trustees of the American Medical Association as soon as possible."

REPORT ON MEDICAL PRACTICES

The House passed a substitute resolution offered by the Reference Committee on Insurance and Medical Service to implement the findings and recommendations of the Committee on Medical Practices (Truman Committee), which studied the basic causes leading to certain unethical practices and unfavorable publicity. The resolution, adopted with the proviso that it is subject to review by legal counsel, includes the following points:

"That a Continuing Committee on Medical Practice be created in the American Medical Association to conduct a study of the relative value of diagnostic, medical and surgical services and to report its findings and recommendations to this House in the same manner as is now followed by other committees and councils of the Association;

"That this committee shall consist of five members of the House appointed by the Speaker, three of whom shall be general practitioners; . . .

"That this committee be directed to utilize all possible means to stimulate the formation of a department of general practice in each medical school;

"That the American Medical Association approve of the medical school teaching programs which afford the medical student opportunity for experience in the general practice of medicine;

"That the representatives of the American Medical Association on the Joint Commission on Accreditation of Hospitals be instructed to stimulate action by that body leading to the warning, provisional accreditation or removal of accreditation of community or general hospitals which exclude or arbitrarily restrict hospital privileges for generalists as a class regardless of their individual professional competence, after appeal to the Commission by the County Medical Society concerned;

"That this committee cooperate in every way and assist the Public Relations Deptment of the American Medical Association to present a program of public education designed to bring about a better understanding of all fields of medical practice, and

"That this committee use its full influence to discourage any arbitrary restrictions by hospitals against general practitioners as group or as individuals."

In a complementary action on the same subject, the House also approved a supplementary report of the Board of Trustees which included the following suggestions:

1. All non-surgical groups should be asked for their suggestions and cooperation in carrying out a public education program on the value of diagnostic and medical work.

2. The various specialty boards should be encouraged to reappraise the practice restrictions on their board diplomates.

3. The American Medical Association should continue to discourage arbitrary restrictions by hospitals against general practitioners.

4. Organized medicine is "ready, willing and able to solve satisfactorily its own problems, and such assurance should be given to the American Hospital Association or any other group concerning itself with such problems."

GUIDES FOR GRIEVANCE COMMITTEES

The House approved the report of the Committee to Recommend Guides for Grievance or Mediation Committees and commended the committee for "their superb approach to this problem." Purpose of the guides is "to promote general uniformity of organization and function of grievance committees—and better understanding of their purposes—without interfering with the inherent autonomy of constituent medical associations. Consituent associations are therefore urged to implement these guides without delay."

The Reference Committee on Miscellaneous Business made the following recommendations which were adopted by the House:

"Your reference committee desires to support the recommendations that a brochure be published promptly which will outline the recommendations regarding the activities of Grievance Committees and that this brochure be given wide distribution.

"We recommend also that there be an appendix to this brochure in which additional, practical suggestions shall be included.

"We desire also to support the contention that there should be no equivocation concerning the naming of such committees and we recommend that a uniform policy be adopted in which they are called frankly 'Grievance Committtees.'

"Finally, your reference committee recommends that because of the many variables, including the laws of the several states, which may influence the operations or procedures followed by State Grievance Committees, legal counsel shall be sought at the local level within the states."

MEDICAL ETHICS

A proposed revision of the "Principles of Medical Ethics and Precepts of Manners of the American Medical Association" was submitted to the House by the Council on Constitution and Bylaws. The following reference committee suggestion was adopted by the House:

"In discussion it became evident that there was need for wide distribution of these principles and careful study of the proposed changes not only by this Reference Committee but also by all members of the House and in fact all members of the Association. It seemed desirable also that the two Councils (Council on Constitution and Bylaws and the Judicial Council) should meet in joint session to consider these proposals. Your Reference Committee therefore recommends that these proposals be tabled for further consideration at the next annual session of the House to be held in Chicago in June, 1956.

"In the meantime, it is recommended that these proposals in their entirety be widely publicized and that consideration be given to publishing, in the Journal of the American Medical Association and also in state medical journals, these proposed changes in the Principles. It is also recommended that consideration be given to the mailing of copies to each member of the Association. Finally, your Reference Committee recommends that prior to the meeting in Chicago next June the Council on Constitution and Bylaws and the Judicial Council meet in joint session to consider these proposed changes."

In another action on revisions of medical ethics, the House also approved a plan requiring that all resolutions dealing with changes in the Principles of Medical Ethics shall be considered over a period between sessions of the House before final adoption.

MISCELLANEOUS ACTIONS

Among many other actions on a variety of other subjects, the House of Delegates also:

Recommended that the Board of Trustees give consideration to a dues increase for all Association members, with the increase designated for contribution to the American Medical Education Foundation;

Adopted a resolution on the practice of pathology declaring opposition to "the division of any branch of medical practice into so-called technical and professional services";

Recommended that further purchases and distribution of Salk polio vaccine be carried on by the presently available commercial avenues used for other immunizing agents, and that all vaccines, once proven, should enter the usual channels of distribution;

Approved appointment of the A.M.A. committee to study the prevention of highway accidents;

Commended the Women's Auxiliary of the A.M.A. for its financial contributions in support of medical education and requested the Auxiliary to continue its active efforts;

Commended the Sears Roebuck Foundation for its thoughtfulness and foresight in sponsoring the new plan for financial assistance in establishing medical practice units;

Received progress reports from the Commission on Medical Care Plans and from the A.M.A. Law Department on its studies of professional liability;

Approved a Board of Trustees recommendation that the State Journal Advertising Bureau be separated from the American Medical Association and be given full autonomy;

Congratulated the physicians of Iowa for their efforts in supporting the position that the practice of medicine is the right

of the individual, and

Approved the selection of Minneapolis for the 1958 Clinical Meeting and Chicago for the 1960 Annual Meeting.

OPENING SESSIONS

Dr. Elmer Hess, A.M.A. President, told the opening session of the House that complacency should be regarded as the medical profession's greatest enemy. Although good progress is being made in informing the public and the profession of the objectives of organized medicine, he said, educational efforts must be intensified and the list of physicians' tangible accomplishments for the health benefit of the public must be increased.

Dr. Leo H. Bartemeier, Chairman of the A.M.A. Council on Mental Health, told the House that the new Joint Commission on Mental Illness and Health will be ready to embark on its nation-wide study and re-evaluation of the human and economic problems of mental illness after the first of the year. Dr. Bartemeier, who is Chairman of the Board of Trustees of Commission, appeared before the House to explain the functions of the new commission, which was organized to carry out the Mental Health Study Act passed by Congress earlier this year without a dissenting vote in either house.

MEDICAL EDUCATION CONTRIBUTIONS

The A.M.A. Board of Trustees announced that it again has appropriated $100,000 to be contributed to the American Medical Education Foundation for the support of medical schools. The California Medical Association presented a $25,000 check to the AMEF, and the Utah State Medical Society announced an $11,000 contribution.

George F. Lull, M.D.
Secretary-General Manager
American Medical Association

With the tuberculosis death rate continuing its gratifying sharp decline, the tuberculin reaction is becoming increasingly important in differential diagnosis. James E. Perkins, M.D., Journal-Lancet, April, 1955.

BOOK REVIEWS

COUNSELING IN MEDICAL GENETICS. By Sheldon C. Reed, Director, Dight Institute for Human Genetics, University of Minnesota. Pp. 268. Cloth. Price, $4.00, Philadelphia: W. B. Saunders Company, 1955.

Medical genetics counseling based on scientifically sound information is a new phase in the field of general medical practice. The accumulation and dissemination of facts about human genetics by a center where individuals may receive education and consequent understanding of problems due to their heredity is certainly a new and promising development in our complex society.

Most of the questions asked by patients revolve about the subject of human anomalies and how heredity works for each one of them. The risk of other children being born with the same abnormality, as fibrosis of the pancreas, mongolism, nervous system malformations, club foot, harelip and cleft palate, congenital heart disease, mental retardation, and a host of others, is very important to the anxious and disappointed parents, who wonder if they may look forward to having normal children.

The author makes no pretense to completeness in this small book. Only traits which appear with a frequency of better than one in one thousand births are considered.

The chapters on schizophrenia and manicdepressive psychosis point out the importance of a knowledge of the genetic history of individuals, since children of schizophrenics have a high incidence of the disease. Adoption agencies will certainly need to have accurate genetic histories on babies they place. "Presumably all children from a schizophrenic pair of parents have the genes present which will allow the disease to become manifest if the environmental situation becomes favorable for development of the disease".

The book consists of twenty-nine short chapters, an appendix listing alphabetically the type of inheritance and frequency of various diseases, a list of the literature cited, and an index. The appendix is very useful as a reference to the various diseases with an inheritance incidence. Physicians will find the material pleasantly presented

and informative; social workers and those specialists dealing with mental disease may find it of considerable assistance.

THE RELIEF OF SYMPTOMS. By Walter Modell, M.D., Associate Professor of Clinical Pharmacology, Cornell University. Pp. 450. Cloth. Price, $8.00, Philadelphia: W. B. Saunders Company, 1955.

This book is intended as a practical guide to the problems of providing the patient with relief from his distress. The author recognizes the importance of making an accurate diagnosis and achieving a cure, but while in the process of doing so, the patient must be given comfort without altering the course of the disease except to suppress undesirable adaptive reactions and without masking the course of the illness.

The author stresses the importance of understanding the personality of the patient in order to be able to evaluate successfully the importance of the complaint in relation to his disease. The dangers of allergy and toxic effects of drugs are emphasized.

The information presented is both basic and extensive. There are thirty chapters in all, the last one being on cortisone and the masking of symptoms.

While emphasis is placed on the relief of symptoms, the author of necessity discusses the clinical pharmacology of the various drugs used in obtaining such relief, and he has done a marvelous piece of work in discussing symptom relief. The practicality of the information might have been further increased had he given a brief, concise method which he found useful for each major symptom. The fields covered are so broad that some of the statements made may not be based on actual clinical experience of the author. For example, in the chapter on skeletal muscle spasm, statements are made regarding the hazards of curare and curare-like drugs, which are not consistent with present day clinical experience.

CARDIAC DIAGNOSIS — A PHYSIOLOGIC APPROACH. By Robert F. Rushmer, M.D., Associate Professor of Physiology and Biophysics, University of Washington. Pp. 447. Cloth. Price, $11:50, Philadelphia: W. B. Saunders Company, 1955.

Stressing accurate diagnosis as the prime objective before proper therapy, either medical or surgical, can be instituted in cases of cardiac disease, the author reviews early in this volume the basic anatomic, functional, and physical properties of the entire circulatory system. A proper evaluation cannot be made by merely interpreting the patient's symptoms and objective signs, as these vary considerably in cardiac diseases. As the subtitle indicates, the problem of cardiac diagnosis is discussed through a physiologic approach delving into the mechanisms behind cardiac disorders. Greater accuracy in diagnosis is thus assured through the application of basic physiologic principles.

The book is divided into five parts. Part I describes the anatomy and the functional character of each component of the cardiovascular system. The 3 chapters of Part II are devoted to the regulation of the peripheral vascular system and of the heart. The topics included in Part III are congestive failure and cardiac reserve. The etiology of congestive heart failure is discussed in detail. Part IV presents various methods of cardiac diagnosis including their usefulness and limitations in clinical problems. Part V fittingly deals with the diagnostic procedures discussed previously in relation to problems encountered clinically among the five main categories of heart disease.

We highly recommend the book to all those interested in heart disease, whether medical student, internist, or cardiac specialist.

PEPTIC ULCER: DIAGNOSIS AND TREATMENT. By Clifford J. Barborka, M.D., and E. Clinton Texter, Jr., M.D., respectively, Associate Professor of Medicine, and Associate in Medicine, Northwestern University. Cloth. Pp. 290, with 33 illustrations. Price, $7.00, Boston: Little, Brown and Co., 1955.

This book is intended as a ready reference for the practicing physician who treats and guides the management of the peptic ulcer patient.

The authors are to be congratulated for having prepared this complete, clearly written, and systematically outlined story of the diagnosis and treatment of peptic ulcer in all of its phases. The detailed drug and dietary procedures outlined are very helpful to the reader who is looking for the

latest opinions in the treatment of peptic ulcer. The extensive clinical experience of the authors is apparent in the concise method by which the information is presented.

Bibliography is supplied at the end of each chapter; an appendix of recipes for foods commonly used in peptic ulcer management, together with sample menus, add to the practical value of this book. It is highly recommended to the practicing physician.

ION EXCHANGE AND ADSORPTION AGENTS IN MEDICINE: THE CONCEPT OF INTESTINAL BIONOMICS. By Gustav J. Martin, Sc.D., Research Director, National Drug Company, Philadelphia. Pp. 333, with 26 illustrations. Cloth. Price, $7.50, Boston: Little, Brown and Company, 1955.

Dr. Martin has devoted many years to the investigation of ion exchange resins and adsorption agents for medical use. The problem of presenting absorption of harmful toxic agents from the gastrointestinal tract is Dr. Martin's primary consideration in this book.

There are ten chapters. The first one discusses ions and solutions, and the importance of ions in electrolyte and fluid balance. The theories of biological relativity and biological antagonism are discussed. Several of the chapters which follow discuss the chemistry of anion and cation exchange resins and their medical applications in the treatment of peptic ulcers and intestinal infections. Laboratory and clinical data are presented. The pharmacology of the resins is discussed in minute detail in their action in the processes of absorption and adsorption.

In the final chapter, the author presents very valuable information relating to vitamin and amino acid synthesis in the gastrointestinal tract, antibiotics, dietary factors influencing intestinal flora, destruction of nutrients by intestinal bacteria, and the formation of toxic chemicals by intestinal bacteria.

An intensive bibliography and a complete index enhance the reference value of this book. Hospital and medical libraries and scientists interested in resins will find this book a welcome addition, and a stimulus to new fields of thinking in disease prevention in man.

OFFICE PROCEDURES. By Paul Williamson, M.D., Pp. 412. Cloth. Price, $12.50, Philadelphia: W. B. Saunders Company, 1955.

All hospital residents, and particularly those on emergency service, and every young physician will delight in having a copy of this informative atlas of office procedures. Surgeons, too, will find the well illustrated office surgical techniques intriguing. The simple methods described in localizing and removing foreign bodies are especially noteworthy.

The extensive coverage of so many of the body systems is this book's amazing feature. The author includes sections on ear, nose and throat, eye, musculoskeletal system, gynecology, obstetrics, urology, proctology, pediatrics, minor surgery and internal medicine. There are also sections devoted to anesthesia, physiotherapy, the small laboratory, roentgenography, and psychological testing.

With regard to the latter, special mention must be made of an uncomplicated method offered. The patient is given a series of one hundred questions which he is asked to answer "true" or "false" on a separate tally sheet, eliminating the necessity of a written answer to each specific question. The number of "true" answers gives an indication as to the presence or extent of psychoneurotic tendencies.

A complete index is included in this practical book for use in daily practice.

BASIC SURGICAL SKILLS, A MANUAL WITH APPROPRIATE EXERCISES. By Robert Tauber, M.D., Assistant Professor of Gynecology and Obstetrics, Graduate School of Medicine, University of Pennsylvania. Pp. 75. Cloth. Price, $3.75, Philadelphia: W. B. Saunders Company, 1955.

Surgical residents and young surgeons will delight in the author's ingenious and practical exercises for training surgeons' fingers. The acquisition of a high grade of technique perfection is taught through the training of the hands in the handling of sutures and various instruments. Young hands can still be molded; the old will not yield to new tricks.

1776—MEDICAL SOCIETY OF DELAWARE—1956

INCORPORATED 1789

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D. D. Burch, Wilmington
E. W. Hainlen, Marshallton
A. J. Morris, Wilmington
L. D. Phillips, Wilmington
W. C. Pritchard, Jr., Smyrna
H. G. Neese, Wyoming
Felix Mick, Milford
C. M. Moyer, Laurel

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L. L. Fitchett, Milford
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A. H. Clagett, Jr., Wilmington
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J. L. Fox, Seaford

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D. H. Aitkin, Wilmington
R. L. Dewees, Wilmington
L. B. Flinn, Wilmington
J. J. Lazzeri, Smyrna
T. J. Tobin, Milton

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J. C. Pierson, Wilmington
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Bruce Barnes, Seaford

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S. W. Rose, Wilmington
F. S. Skura, Wilmington
V. D. Washburn, Wilmington
O. A. James, Milford

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E. S. Resnick, Wilmington
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R. R. Layton, Jr., Dover
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S. G. Elbert, Wilmington
E. R. Mayerberg, Wilmington
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A. L. Shands, Jr., Wilmington
R. R. Layton, Jr., Dover
J. S. McDaniel, Sr., Dover
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J. E. Marvil, Laurel

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S. W. Bartoshesky, Wilmington
P. D. Gordy, Wilmington
D. W. MacKelcan, Wilmington
C. M. Moyer, Laurel

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MRS. H. T. MCGUIRE, *President-elect*, New Castle
MRS. C. C. FOOKS, *Vice-President*, Milford
MRS. R. D. SANDERS, *Recording Secretary*, Wilmington
MRS. W. C. PRITCHARD, JR., *Corresponding Secretary*, Smyrna
MRS. H. J. LAGGNER, *Treasurer*, Smyrna

NEW CASTLE COUNTY MEDICAL SOCIETY

Meets Third Tuesday

CHARLES LEVY, *President*
J. C. PIERSON, *President-elect*
D. D. BURCH, *Vice-President*
W. W. BRIGGS, *Secretary*
A. L. INGRAM, JR., *Treasurer*
E. C. SYROVATKA, *LL.D., Executive Sec.*

Councilors: R. B. Thomas (1956); A. D. King (1957); A. H. Clagett, Jr. (1958).

Delegates (1956): R. E. Allen, W. L. Bailey, J. M. Barsky, Jr., S. W. Bartoshesky, W. W. Briggs, Italo Charamella, J. A. Chrzanowski, A. J. Fleming, F. J. Gilday, Catherine P. Johnson, F. A. Jones, D. W. MacKelcan, T. E. Resnick, F. S. Skura, H. A. Tarrant, M. A. Tarumianz.

Alternates (1956): E. M. Aikman, F. A. Bowdle, C. A. D'Alonzo, F. J. Di Cecco, S. G. Elbert, H. W. Gray, R. C. Hayden, L. Katzenstein, J. W. Kerrigan, L. T. Lang, H. L. Reed, H. J. Repman, Jr., R. D. Sanders, W. C. Silverman, T. B. Strange, L. W. Whitney.

Delegates (1957): J. W. Alden, G. J. Boines, S. W. Casscells, C. R. Donoho, I. M. Flinn, Jr., R. W. Frelick, P. D. Gordy, F. S. Hassler, J. W. Howard, E. G. Laird, H. T. McGuire, D. J. Preston, S. W. Rennie, C. F. Richards, M. F. Squires, H. H. Stroud.

Alternates (1957): D. H. Aitkin, T. H. Baker, J. W. Barnhart, D. D. Burch, R. L. Dewees, J. R. Durham, E. F. Fantazier, J. H. Furlong, Jr., Jack Gelb, J. J. Graff, J. W. Kerrigan, D. J. King, J. W. Maroney, M. B. Pennington, T. H. Pennock, E. J. Szatkowski.

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Woman's Auxiliary

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KENT COUNTY MEDICAL SOCIETY

Meets Second Sunday

O. J. POLLAK, *President*, Dover
J. J. LAZZERI, *Vice President*, Smyrna
J. R. MCNINCH, *Sec.-Treas.*, Dover

Councilors: E. H. Mercer (1956), Dover; J. R. Fox (1958), Dover.

Delegates: R. W. Comegys (1956), Clayton; E. R. McNinch (1956), Dover; H. J. Laggner (1957), Smyrna.

Alternates: R. J. Bishop (1956), Dover; G. R. Spong (1956), Dover; R. R. Layton (1957), Dover.

Woman's Auxiliary

MRS. E. H. MERCER, *Pres.*, Dover; MRS. J. R. FOX, *Sec.-Treas.*, Dover

SUSSEX COUNTY MEDICAL SOCIETY

Meets Second Tuesday

T. J. TOBIN, *President*, Milton
W. P. ELLIS, *Vice-President*, Laurel
P. C. TRICKETT, *Secretary-Treasurer*, Lewes

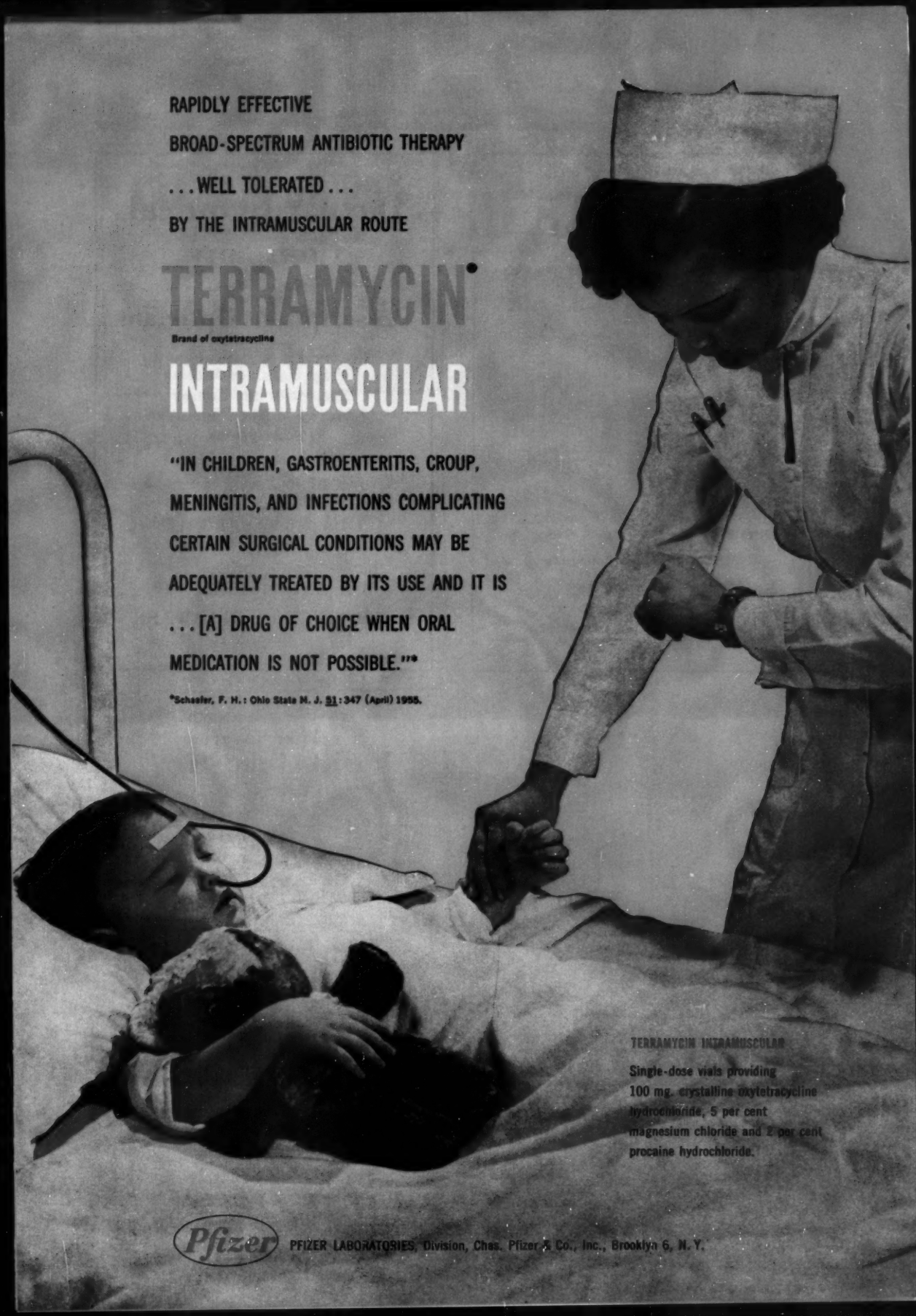
Councilors: L. M. Dobson (1957), Milford; J. E. Marvil (1958), Laurel.

Delegates: J. W. Annand (1956), Georgetown; Bruce Barnes (1956), Seaford; O. A. James (1956), Milford; James Beebe, Jr. (1957), Lewes; L. L. Fitchett (1957), Milford; J. L. Fox (1957), Seaford.

Alternates: Catherine C. Gray (1956), Bridgeville; C. M. Moyer (1956), Laurel; C. G. Pierce, Jr. (1956), Rehoboth; J. W. Lynch (1957), Seaford; E. L. Stambaugh (1957), Lewes; T. J. Tobin (1957), Milton.

Woman's Auxiliary

MRS. L. L. FITCHETT, *President*, Milford.
MRS. G. V. WOOD, *Vice-Pres.*, Millsboro.
MRS. C. C. FOOKS, *Secretary*, Milford.
MRS. JAMES BEEBE, JR., *Treasurer*, Lewes.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*Schaefer, F. H.: Ohio State M. J. 51:347 (April) 1955.
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